Seattle
Department of Human Resources

SPOG - Medical, Dental and Vision Insurance Enrollment Form*

Employee Information: (Please print)

Last Name	First Name	Employee # or last 4-digits of SSN	Birth Date (mm/dd/yyyy)

Enrollment Status *: (Please check one)

◯ **New Hire** ◯ **New Hire (Temporary Benefits Eligible - TBE)** ◯ **New Marriage/Domestic Partnership** (Attach marriage/domestic partner affidavit form)	◯ **Birth/Adoption** ◯ **Change Coverage** ◯ **Name Change Only**	◯ **Loss of other coverage** (attach proof of other coverage)

*Also used for changes within 30-day enrollment period and qualifying events (e.g. moving out of service area, union plan change)

Coverage Options:

Medical (Please select one medical option below)	**Dependent Options** (with or without children)	**Employee Premium Share**
Aetna Preventive Plan	◯ Employee & Spouse/Domestic Partner	$102.88
Aetna Traditional Plan (LEOFF I)	◯ Employee & Spouse/Domestic Partner	$76.32
Aetna Traditional Plan (LEOFF II)	◯ Employee & Spouse/Domestic Partner	$91.72
Kaiser Permanente Standard Plan	◯ Employee & Spouse/Domestic Partner	$76.26
Kaiser Permanente Deductible Plan	◯ Employee & Spouse/Domestic Partner	$56.54
Waive Medical Coverage	◯ Yes	Not Applicable
Dental (Please select one dental plan below)	**Dependent Options** (with or without spouse/DP/children)	**Employee Premium Share**
Delta Dental of Washington	◯ Yes	$0.00
Dental Health Services+	◯ Yes	$0.00
Vision	**Dependent Options** (with or without spouse/DP/children)	**Employee Premium Share**
VSP	Automatically Enrolled	$0.00

+Dental Health Services is a Limited Health Care Service Contractor (100 West Harrison Street, Suite S-440, South Tower, Seattle, WA 98119

Add Dependent Coverage Information:

List all eligible dependents to be included. Attach another page 2 for additional dependents. If you enroll a dependent, the City's business partner, Alight Solutions, will send a letter to your home requesting documents that confirm the eligibility of your dependent. For more information visit https://bit.ly/Citydev

Spouse / Domestic Partner

Reset this section

Relationship	◯ Spouse	◯ Domestic Partner (**Yes - IRS Tax Dependent**)	◯ Domestic Partner (**No - Not IRS Tax Dependent**)

Last Name	First Name	MI	SSN	Birth Date (mm/dd/yyyy)	Gender
			- -		◯ Male ◯ Female ◯ X***

Enroll In (check boxes as applicable) ☐ Medical ☐ Dental ☐ Vision

Dependent Child #1

Relationship	◯ Employee's Child ◯ Son ◯ Daughter	◯ Stepchild ◯ Son ◯ Daughter	◯ Domestic Partner's Child ◯ Son ◯ Daughter	◯ Legal Guardian ◯ Son ◯ Daughter

Is the child incapacitated or Disabled? ◯ Yes ◯ No
(If yes and your child is age 26 or older, contact Benefits Rep to begin verification process)

Last Name	First Name	MI	SSN	Birth Date (mm/dd/yyyy)	Gender
			- -		◯ Male ◯ Female ◯ X***

Enroll In (check boxes as applicable) ☐ Medical ☐ Dental ☐ Vision

Dependent Child #2

Relationship	◯ Employee's Child ◯ Son ◯ Daughter	◯ Stepchild ◯ Son ◯ Daughter	◯ Domestic Partner's Child ◯ Son ◯ Daughter	◯ Legal Guardian ◯ Son ◯ Daughter

Is the child incapacitated or Disabled? ◯ Yes ◯ No
(If yes and your child is age 26 or older, contact Benefits Rep to begin verification process)

Last Name	First Name	MI	SSN	Birth Date (mm/dd/yyyy)	Gender
			- -		◯ Male ◯ Female ◯ X***

Enroll In (check boxes as applicable) ☐ Medical ☐ Dental ☐ Vision

Dependent Child #3

Relationship	◯ Employee's Child ◯ Son ◯ Daughter	◯ Stepchild ◯ Son ◯ Daughter	◯ Domestic Partner's Child ◯ Son ◯ Daughter	◯ Legal Guardian ◯ Son ◯ Daughter

Is the child incapacitated or Disabled? ◯ Yes ◯ No
(If yes and your child is age 26 or older, contact Benefits Rep to begin verification process)

Last Name	First Name	MI	SSN	Birth Date (mm/dd/yyyy)	Gender
			- -		◯ Male ◯ Female ◯ X***

Enroll In (check boxes as applicable) ☐ Medical ☐ Dental ☐ Vision

***X means a gender that is not exclusively male or female

Note: It is a crime to knowingly provide false, incomplete, or misleading information to an insurance company for the purpose of defrauding the insurance company. Penalties may include imprisonment, fines and denial of insurance benefits.

Coverage Acknowledgement:

Reset this section

I Accept Coverage

Previously submitted enrollment information for a specific insurance plan is superseded by changes indicated on this form. I certify that my family members and I are eligible for the coverage requested. I authorize the City to deduct from my earnings any premium I am required to pay for the coverage I selected above.

By signing below, I declare that the information on this form is true, correct and complete to the best of my knowledge; that I have read and understood the election form and descriptive material covering the options provided under the City of Seattle's benefit plans. I authorize the insurance carriers to obtain, examine or release information needed to coordinate benefits or process claims for myself or my family. I understand I may be subject to disciplinary action and/or repayment of any claims paid by my health plan or premiums paid by my employer if I have provided false, incomplete or misleading information, or fail to update this information in accordance with eligibility guidelines.

Employee's Signature: Date (mm/dd/yyyy):

I Waive Medical Coverage Only

I understand that by waiving City of Seattle medical insurance, my dependents and I will not have medical coverage through the City. I understand I must enroll in a vision and dental plan. **I waive medical coverage for myself and my dependents.**

Other opportunities to enroll in medical benefits in the future:

- If you have medical coverage elsewhere and lose your other coverage, you may enroll within 30 days of the loss of the other coverage upon providing proof of continuous medical coverage. If you have a qualifying change in family status, you may enroll within 30 days (or 60 days for a new child/adoption) of that change. If you leave City employment or go on a leave of absence, you will not be eligible to obtain your medical coverage under the federal COBRA law through the City; however, if you retire you will be eligible to enroll in a City retiree medical plan.
- If you decline coverage and have no medical insurance elsewhere, you will NOT be eligible to enroll in a medical plan until the next annual Open Enrollment unless you have a qualifying change in family status. If you leave City employment or go on a leave of absence, you will not be eligible to obtain your medical coverage under the federal COBRA law; however, if you retire you will be eligible to enroll in a City retiree medical plan.

Employee's Signature: Date (mm/dd/yyyy):